Medicare Beneficiary Quality Improvement Project (MBQIP) Momentum!

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Idaho CAH–RHC–Free Medical Clinic Annual Conference

Boise, ID

November 10, 2016

~~Five~~ Six Good Things

Image credit: Marilyn Grafstrom

Roseau, MN

"You're braver than you believe,
stronger than you seem,
and smarter than you think."

– Quote from the 1997 Disney movie:
"Pooh's Grand Adventure: The Search for Christopher Robin"

Learning Objectives

- Understand MBQIP
- Relate the importance of MBQIP
- Recognize the benefits of MBQIP participation

Image credit: Marilyn Grafstrom

Image credit: Marilyn Grafstrom

Illusory Superiority

Image credit: Marilyn Grafstrom

A cognitive bias whereby individuals overestimate their own qualities and abilities, relative to others.

This is evident in a variety of areas including intelligence, performance on tasks or tests, and the possession of desirable characteristics or personality traits.

It is one of many positive illusions relating to the self, and is a phenomenon studied in social psychology.

(Source: https://en.wikipedia.org/wiki/Illusory_superiority, 10/18/16)

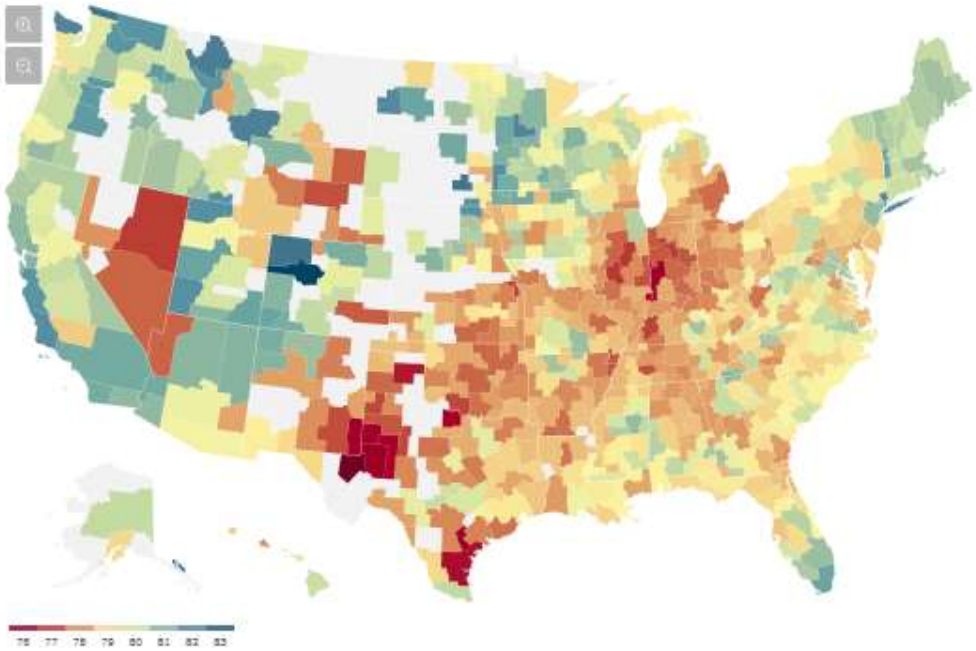
The New York Times

TheUpshot

The Rich Live Longer Everywhere. For the Poor, Geography Matters.

By NEIL IRWIN and QUOCTRUNG BUI APRIL 11, 2014

Life expectancy of 40-year-olds with household incomes **below $28,000**, adjusted for race*



StratisHealth

Rural Quality Improvement Technical Assistance

Am J Prev Med. 2014 Feb;46(2):e19-29. doi: 10.1016/j.amepre.2013.10.017.

Widening rural-urban disparities in life expectancy, U.S., 1969-2009.

Singh GK[1], Siahpush M[2].

⊕ Author information

Abstract

BACKGROUND: There is limited research on rural-urban disparities in U.S. life expectancy.

PURPOSE: This study examined trends in rural-urban disparities in life expectancy at birth in the U.S. between 1969 and 2009.

METHODS: The 1969-2009 U.S. county-level mortality data linked to a rural-urban continuum measure were analyzed. Life expectancies were calculated by age, gender, and race for 3-year time periods between 1969 and 2004 and for 2005-2009 using standard life-table methodology. Differences in life expectancy were decomposed by age and cause of death.

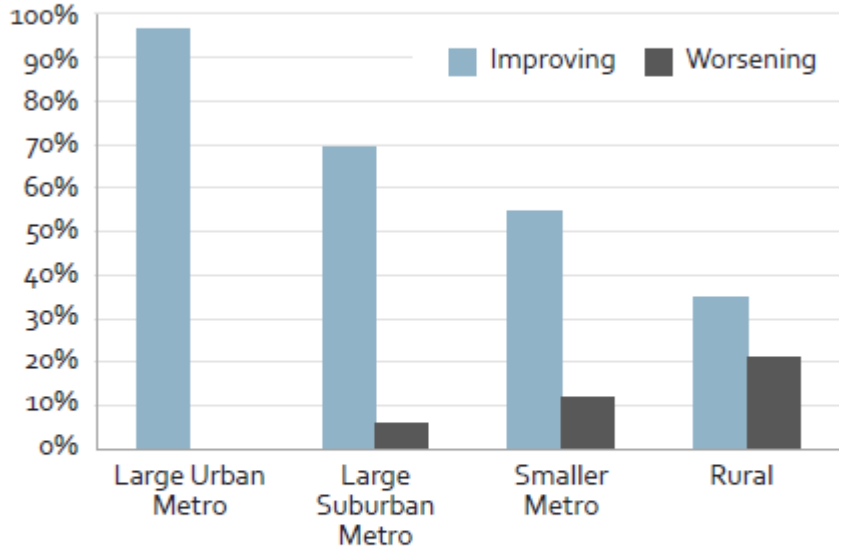
RESULTS: Life expectancy was inversely related to levels of rurality. In 2005-2009, those in large metropolitan areas had a life expectancy of 79.1 years, compared with 76.9 years in small urban towns and 76.7 years in rural areas. When stratified by gender, race, and income, life expectancy ranged from 67.7 years among poor black men in nonmetropolitan areas to 89.6 among poor Asian/Pacific Islander women in metropolitan areas. Rural-urban disparities widened over time. In 1969-1971, life expectancy was 0.4 years longer in metropolitan than in nonmetropolitan areas (70.9 vs 70.5 years). By 2005-2009, the life expectancy difference had increased to 2.0 years (78.8 vs 76.8 years). The rural poor and rural blacks currently experience survival probabilities that urban rich and urban whites enjoyed 4 decades earlier. Causes of death contributing most to the increasing rural-urban disparity and lower life expectancy in rural areas include heart disease, unintentional injuries, COPD, lung cancer, stroke, suicide, and diabetes.

CONCLUSIONS: Between 1969 and 2009, residents in metropolitan areas experienced larger gains in life expectancy than those in nonmetropolitan areas, contributing to the widening gap.

Published by American Journal of Preventive Medicine on behalf of American Journal of Preventive Medicine.

Counties with Improving or Worsening Premature Death Rates, 1999-2013[1]

Percent of counties



Key Findings

- Rural counties have consistently had the highest premature death rates and, following a few years of improvement, overall rates of premature death are increasing.
- Nearly one in five Rural counties has experienced worsening premature death rates over the past decade.

(Source: http://www.countyhealthrankings.org/reports/key-findings-2016, 10/18/2016)

Death Rates Rise At Geographically Isolated Hospitals, Study Finds

“For 15 years, Congress has bestowed special privileges to some small remote hospitals, usually in rural areas, to help them stay afloat. Medicare pays them more than it pays most hospitals and exempts them from financial pressure to operate efficiently and requirements to reveal how their patients fare. Nearly one in four hospitals qualifies for the program”.

“Despite these benefits, there’s new evidence that the quality of many of these hospitals may be deteriorating. A study published Tuesday found that during the past decade the death rates of patients at these critical access hospitals were growing while mortality rates at other hospitals were dropping.”

(Source: http://khn.org/news/critical-access-hospitals-fare-poorly-on-death-rates/, 10/18.16)

Mortality Rates for Medicare Beneficiaries Admitted to Critical Access and Non–Critical Access Hospitals, 2002-2010

Karen E. Joynt, MD, MPH
E. John Orav, PhD
Ashish K. Jha, MD, MPH

Importance Critical access hospitals (CAHs) provide inpatient care to Americans living in rural communities. These hospitals are at high risk of falling behind with respect to quality improvement, owing to their limited resources and vulnerable patient populations. How they have fared on patient outcomes during the past decade is unknown.

Objective To evaluate trends in mortality for patients receiving care at CAHs and compare these trends with those for patients receiving care at non-CAHs.

Design, Setting, and Patients Retrospective observational study using data from Medicare fee-for-service patients admitted to US acute care hospitals with acute myocardial infarction (1 902 586 admissions), congestive heart failure (4 488 269 admissions), and pneumonia (3 891 074 admissions) between 2002 and 2010.

Main Outcome Measures Trends in risk-adjusted 30-day mortality rates for CAHs and other acute care US hospitals.

Results Accounting for differences in patient, hospital, and community characteristics, CAHs had mortality rates comparable with those of non-CAHs in 2002 (composite mortality across all 3 conditions, 12.8% vs 13.0%; difference, −0.3% [95% CI, −0.7% to 0.2%]; $P=.25$). Between 2002 and 2010, mortality rates increased 0.1% per year in CAHs but decreased 0.2% per year in non-CAHs, for an annual difference in change of 0.3% (95% CI, 0.2% to 0.3%; $P<.001$). Thus, by 2010, CAHs had higher mortality rates compared with non-CAHs (13.3% vs 11.4%; difference, 1.8% [95% CI, 1.4% to 2.2%]; $P<.001$). The patterns were similar when each individual condition was examined separately. Comparing CAHs with other small, rural hospitals, similar patterns were found.

Conclusions and Relevance Among Medicare beneficiaries with acute myocardial infarction, congestive heart failure, or pneumonia, 30-day mortality rates for those admitted to CAHs, compared with those admitted to other acute care hospitals, increased from 2002 to 2010. New efforts may be needed to help CAHs improve.

JAMA. 2013;309(13):1379-1387 www.jama.com

More than 60 million Americans live in rural areas and face challenges in accessing high-quality inpatient care. In 1997, the US Congress created the Critical Access Hospital (CAH) program[1] in response to increasing rural hospital closures. To qualify, hospitals must have no more than 25 beds and be located at least 35 miles from the nearest alternative source of inpatient care; however, states were given leeway to broaden eligibility, and only 20% of CAHs currently meet this distance requirement.[2] Under the program, CAHs were exempted from prospective payments and instead receive reimbursement at 101% of costs.[3] Additionally, the federal government exempted CAHs from participation in national quality improvement programs.[3-6]

Since the inception of the program, hospitals electing CAH status have seen additional payments from Medicare,[7] improvement in margins compared with nonconverting rural hospitals,[8] and few closures.[7,9] Hundreds of hospitals have joined the program over the past decade—by 2010, nearly 1 in 4 of the nation's hospitals were CAHs.

For editorial comment see p 1410.

Despite these additional financial supports from the government, CAHs still face significant challenges compared with larger, less isolated facilities. Critical access hospitals have fewer financial and human capital resources[10] and care for a rapidly aging population at high risk of poverty and joblessness.[11] Whether current federal

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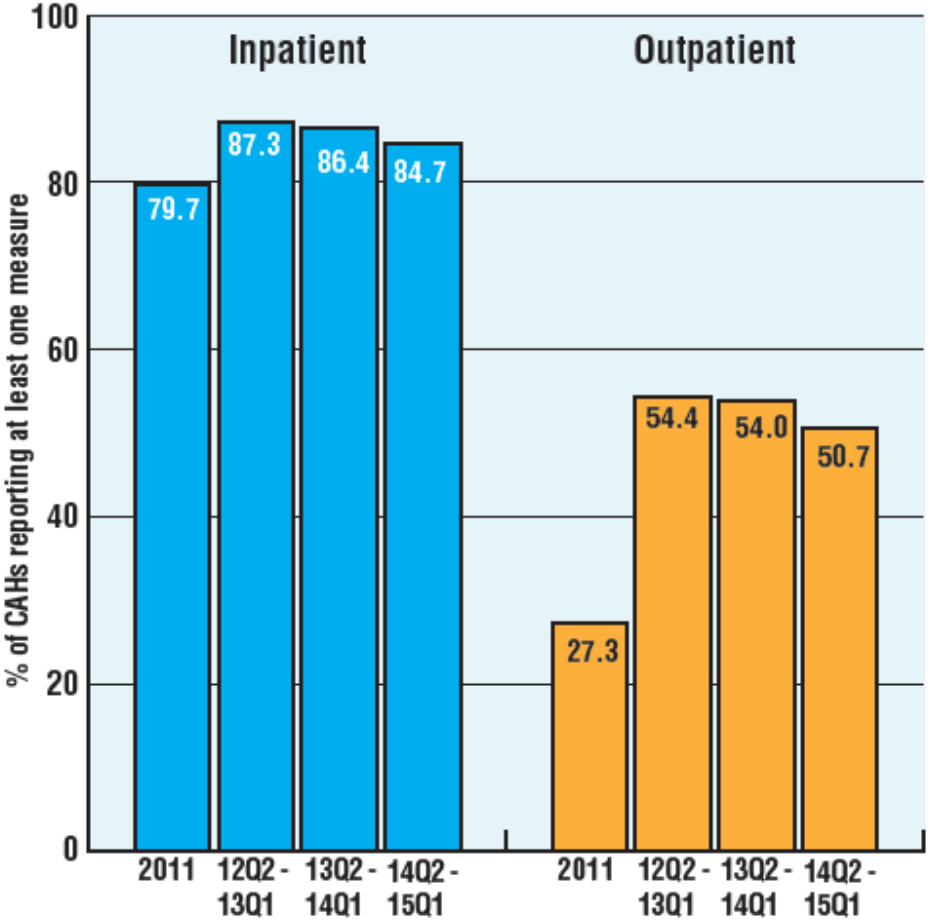
Figure 1. CAH Participation in Hospital Compare, 2011 - 2015 (N=1,336[a])



[a]N value refers to most recent data (Q2 2014 - Q1 2015). Prior years' N values are as follows: 2011 - 1,328; Q2 2012 - Q1 2013, 1,332; and Q2 2013 - Q1 2014, 1,338.

(Source: http://www.flexmonitoring.org/wp-content/uploads/2016/07/DSR-19.pdf, 10/18/2016)

Inception of MBQIP

- FORHP created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Program activity within the core area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve their patient care and operations.

  (Source: https://www.ruralcenter.org/sites/default/files/flex-coordinator-manual/2015/4%20MBQIP%20Overview%20for%20Flex%20Coordinators.pdf, 10/18/16)

Why MBQIP?

- Preparing for the potential future of mandatory CAH reporting (VBP)
- CMS, Insurance Companies, ACOs

(Source: https://www.ruralcenter.org/tasc/events/webinar-medicare-beneficiary-quality-improvement-project-mbqip-refresher, 10/18/16)

Goals of MBQIP

- Reporting common, rural-relevant measures
- Measuring outcomes and demonstrating improvements
- Sharing best practices

Benefits of MBQIP Participation

- Improved patient care
- Improved quality outcomes
- Improved program integrity

MBQIP Required Measures

- Patient Safety
  - OP-27: Influenza vaccination coverage among health care personnel
  - IMM-2: Influenza immunization
- Patient Engagement
  - Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS): Patient Experience Survey
- Care Transitions
  - EDTC: Emergency department transfer communication*

*Not currently a CMS Hospital Measure

MBQIP Required Measures

- Outpatient
  - Acute myocardial infarction (AMI)/Chest Pain
    - OP-1: Median Time to Fibrinolysis
    - OP-2: Fibrinolytic Therapy Received Within 30 Minutes
    - OP-3: Median Time to Transfer to Another Facility for Acute Coronary Intervention
    - OP-4*: Aspirin at Arrival
    - OP-5: Median Time to ECG

*Added to MBQIP for FY2016

MBQIP Required Measures

- ED throughput
  - OP-18*: Median Time from ED Arrival to ED Departure for Discharged ED Patients
  - OP-20: Door to Diagnostic Evaluation by a Qualified Medical Professional
  - OP-22: Left Without Being Seen
- Pain management
  - OP-21: Median Time to Pain Management for Long Bone Fracture

*Added to MBQIP for FY2016

MBQIP Additional Measures

- **Patient Safety**
  - Healthcare Acquired Infections (HAIs), Stroke care, Venous Thromboembolism (VTE), Perinatal care, Surgical care, Pneumonia, Falls, Adverse Drug Events (ADEs), Readmissions, Safety Culture Survey
- **Care Transitions**
  - Discharge Planning, Medication Reconciliation
- **Outpatient**
  - ED-1*, ED-2*

* Although focused on ED Care, these two measures are considered part of the CMS Inpatient Measure set.

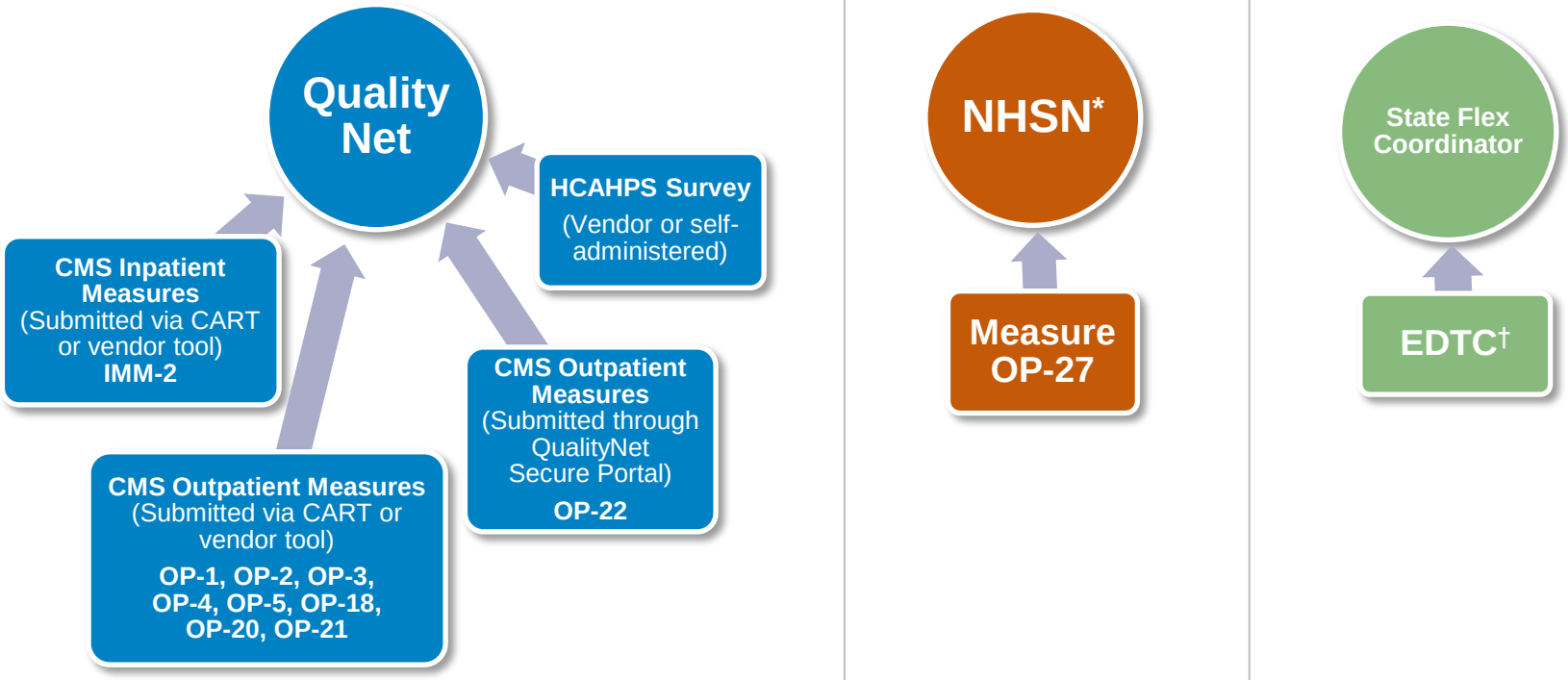
MBQIP Measures

Medicare Beneficiary Quality Improvement Project (MBQIP) Measures

	Patient Safety	*Patient Engagement*	*Care Transitions*	*Outpatient*
Core Improvement Initiatives	**OP-27:** Influenza Vaccination Coverage Among Healthcare Personnel (HCP) *(Facilities report a single rate for inpatient and outpatient settings)* **IMM-2:** Influenza Immunization	**Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** *The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics:* • Communication with Doctors • Communication with Nurses • Responsiveness of Hospital Staff • Pain Management • Communication about Medicines • Discharge Information • Cleanliness of the Hospital Environment • Quietness of the Hospital Environment • Transition of Care *The survey also includes four screener questions and seven demographic items. The survey is 32 questions in length.*	**Emergency Department Transfer Communication (EDTC)** *7 sub-measures; 27 data elements; 1 composite* • EDTC-1: Administrative Communication (2 data elements) • EDTC-2: Patient Information (6 data elements) • EDTC-3: Vital Signs (6 data elements) • EDTC-4: Medication Information (3 data elements) • EDTC-5: Physician or Practitioner Generated Information (2 data elements) • EDTC-6: Nurse Generated Information (6 data elements) • EDTC-7: Procedures and Tests (2 data elements) • All-EDTC: Composite of All 27 data elements	**OP-1:** Median Time to Fibrinolysis **OP-2:** Fibrinolytic Therapy Received within 30 minutes **OP-3:** Median Time to Transfer to another Facility for Acute Coronary Intervention **OP-4:** Aspirin at Arrival **OP-5:** Median Time to ECG **OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients **OP-20:** Door to Diagnostic Evaluation by a Qualified Medical Professional **OP-21:** Median Time to Pain Management for Long Bone Fracture **OP-22:** Patient Left Without Being Seen

Revised on 03/17/2016

Quality Data Reporting Channels for MBQIP Required Measures



*National Healthcare Safety Network †Emergency Department Transfer Communication

Present State of MBQIP

- 98.8% of CAHs have signed MOUs to participate in MBQIP
- 96% of CAHs reported data in at least one quarter in at least one domain in the past year
- As of March 2016: 1,105 CAHs registered with NHSN
  - 45% increase in CAHs reporting OP-27 in 2016
- Updated MBQIP Data Reports

Idaho

- 100% CAH's signed MOU's (27/27)
- 67% CAH's submitted OP 27 to NHSN last season
- 100% CAH participation in HCAHPS
- 100% CAH reporting EDTC
- Population and sampling (it's for your good)

MBQIP Going Forward

- FORHP collaboration with CMS
- National Quality Forum Rural Report
  http://www.qualityforum.org/Publications/2015/09/Rural_Health_Final_Report.aspx
- Increased emphasis on quality improvement
- Continued collaboration and assistance from:
  - TASC
  - RQITA
  - FMT

CMS CAH Conditions of Participation Proposed Rule

"To the extent that the MBQIP meets the proposed requirements for incorporating quality indicator data in its QAPI program, CAH adherence to the requirements of MBQIP is one such way that the CAH's QAPI program data collection requirements can be satisfied."

MBQIP Website

- Information on all MBQIP domains, archived presentations and other valuable resources

Beyond MBQIP…

- Hospital Improvement and Innovation Networks (HIIN)
- Quality Payment Program, Center for Medicare and Medicaid Services
  - A part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Includes:
    - Merit-based Incentive Payment System (MIPS)
    - Alternative Payment Models (APMs)
- State or grant based reporting

Two lenses….

Image credit: Marilyn Grafstrom

Value Based Purchasing 2018 (PPS hospitals)

- Patient and Caregiver-Centered Experience of Care/Care Coordination (25%)
- Safety (25%)
- Clinical Care (25%)
- Efficiency and Cost Reduction (25%)
  - Medicare spending per beneficiary

Patient and Caregiver-Centered Experience of Care/Care Coordination HCAHPS (25%)

1. Communication with Nurses
2. Communication with Doctors
3. Responsiveness of Hospital Staff
4. Pain Management (proposed rule to remove from VBP calculation 2018)
5. Communication about Medicines
6. Cleanliness and Quietness of Hospital Environment
7. Discharge Information
8. Care Transition (3 new questions starting in FY 2018)
9. Overall Rating of Hospital

Safety (25%)

- AHRQ PSI-90 Composite
- Central Line-Associated Bloodstream Infections (CLABSI)
- Catheter-Associated Urinary Tract Infections (CAUTI)
- Surgical Site Infection (SSI): Colon
- SSI: Abdominal Hysterectomy
- Methicillin-resistant Staphylococcus aureus (MRSA)
- C. difficile Infections (CDI)
- PC-01 Elective Delivery Prior to 39 Completed Weeks of Gestation

Patient Safety Indicators 90 (PSI 90)

- PSI 03 Pressure Ulcer Rate
- PSI 06 Iatrogenic Pneumothorax Rate
- PSI 07 Central Venous Catheter-Related Blood Stream Infection Rate
- PSI 08 Postoperative Hip Fracture Rate
- PSI 09 Perioperative Hemorrhage or Hematoma Rate
- PSI 10 Postoperative Physiologic and Metabolic Derangement Rate
- PSI 11 Postoperative Respiratory Failure Rate
- PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rat
- PSI 13 Postoperative Sepsis Rate
- PSI 14 Postoperative Wound Dehiscence Rate
- PSI 15 Accidental Puncture or Laceration Rate

http://www.qualityindicators.ahrq.gov/Downloads/Modules/PSI/V50/TechSpecs/PSI_90_Patient_Safety_for_Selected_Indicators.pdf

Clinical Care Outcomes (25%)

- 30-day mortality, acute myocardial infarction (MORT-30-AMI)
- 30-day mortality, heart failure (MORT-30-HF)
- 30-day mortality, pneumonia (MORT-30-PN)

Efficiency and Cost Reduction (25%)

- MSPB-1 Medicare spending per beneficiary

Image credit: Marilyn Grafstrom

VBP Performance Periods

Image credit: Marilyn Grafstrom

Predictive Positioning

- MBQIP
  - connection with Flex funded activities and SHIP grants
  - Medicare CAH Conditions of Participation proposed changes
- National reporting
  - NHSN, Quality Net
- Patient safety topics with NQF endorsement
  - Fall prevention
  - CAUTI
  - Early elective deliveries
- Global measures
  - IMM – 2
  - OP -27 HCP influenza immunizations
- Clinical care outcomes
  - all cases, all payers readmissions

ACO…
an alignment consideration?

- Risk Standardized, All Condition Readmission
- Documentation of Current Medications in the Medical Record
- Falls: Screening for Future Fall Risk
- Preventive Care and Screening: Influenza Immunization
- Pneumonia Vaccination Status for Older Adults
- Preventive Care and Screening: Body Mass Index Screening and Follow-Up
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan
- Cancer screening (colorectal and breast)
- Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

National Quality Forum Rural Provider Recommendations

After discussion of many of the rural health and setting-specific challenges related to performance measurement of rural providers, the Committee agreed that their recommendations should, at minimum, address four key issues:

- Low case volume
- Need for measures that are most meaningful to rural providers and their patients and families
- Alignment of measurement efforts
- Mandatory versus voluntary participation in CMS quality improvement programs

http://www.qualityforum.org/Publications/2015/09/Rural_Health_Final_Report.aspx

If you don't like where we're going….

Speak up….

Your voice. Louder.

Need MBQIP Help?

MBQIP Resources posted to TASC website:

www.ruralcenter.org/tasc/mbqip

MBQIP TA Questions should be sent to:

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tasc@ruralcenter.org

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Stratis Health is a nonprofit organization that leads collaboration and innovation in health care quality and safety, and serves as a trusted expert in facilitating improvement for people and communities.

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